

Immunization Advisory Committee Meeting
Minutes
July 24, 2012, 9:00 a.m.
109 Governor Street, Mezzanine Conference Room
Richmond, Virginia

The Immunization Advisory Committee shall provide guidance and serve as an advisory body to the Division of Immunization at the Virginia Department of Health. The Committee will address issues related to best practices in immunization in a clinical setting, vaccine supply, vaccine legislation, vaccine preventable disease control, and other key programmatic issues as they arise. The Committee will meet quarterly, agendas will be available prior to the meeting, and minutes of each meeting will be the responsibility of the Division of Immunization staff.

Members Present: Barbara Allison-Bryan, MD (Sentara Pediatric Physicians-Gloucester); Michael Ashby, MD (Martha Jefferson Hospital); Aline Branca, MD (EVMS); Tia Campbell, RN, MSN, NCSN (DOE); Melissa Canaday (VA Native American Community); Michelle Charters, MPH (Project Immunize Virginia); C. W. Gowen, Jr., MD (EVMS); Keri Hall, MD, MPH (VHHA); Heidi Kulberg, MD, MPH (VAAFP); Gwen E. Messler Harry (VCEP); Douglas K. Mitchell, MD (International Adoption and Travel Medicine Clinic); Carolyn Moneymaker, MD (EVMS); Bill Moskowitz, MD (VAAP); Tim Musselman, PharmD (VA Pharmacists Association); Holly Puritz, MD (VACOG); Cindy Robinson, RN (Reston Hospital Center); Jay Schukman, MD (Anthem BC/BS); Laura Lee Viergever (VAHP); Linda D. Wilkinson, MPA (Virginia Association of Free Clinics)

VDH Staff Present: David Goodfriend, MD; Julia Gwaltney, RN; Parham Jaberri, MD; Molly O'Dell, MD; Michael Royster, MD; Peter Troell, MD, MPH; Maureen Dempsey, MD, FAAP; Rebecca Early; Jim Farrell; Laurie Forlano, DO, MPH; Laura Ann Nicolai; Sandy Sommer, PhD; David Trump, MD, MPH, MPA; Jodi Wakeham, RN, PhD

Others Present: Lauren Bull (The Hillbridge Group for VACEP/AAP), Heather Crouch (GlaxoSmithKline Medical Affairs), Ellen Shannon (Sanofi Pasteur)

Members Unable to Attend: Tom Edicola (DMAS), Lilian Peake, MD (VDH), Nancy Welch, MD (VDH), Trinette Randolph (VA Community Health Association), Jeniece Roane, RN, MS, NE-BC (VA Nurses Association), and Sandra Zieve, MD (Patient First).

Welcome/Introduction—Dr. Forlano welcomed attendees, provided background information for new members, and conducted roll call.

Opening Comments—Dr. Dempsey recognized everyone's level of commitment, energy, and interest in VDH's efforts and noted that it would not be possible for VDH to move forward successfully without partnerships and community. She urged the committee members to reach into their specific disciplines and communities to generate ideas, elicit feedback on issues and initiatives, and implement solutions.

Division of Immunization (DOI) Overview—Jim Farrell presented an overview of the division's mission and vision, reviewed its current programs and activities, and highlighted the following:

- *Virginia Vaccines for Children (VVFC)* is an entitlement program that provides vaccine at no cost to children who are Medicaid-eligible, uninsured, American Indian, and Alaska Native. VVFC currently has over 900 facilities enrolled in the program as either a private facility or a public facility. VVFC also provides vaccine to underinsured children but only at federally qualified health centers (FQHCs) and rural health clinics (RHCs). Local health departments (LHDs) also are able to vaccinate underinsured children with vaccine provided through VDH's DOI. This vaccine has been procured through a combination of two funding streams: state general funds and federal 317 direct assistance vaccine funds. Effective October 1, 2012, Virginia's Section 317 vaccine budget will be reduced by 20%, and 317 funds can no longer

support vaccines that will be administered to insured patients. Subsequently, 317-funded vaccines will be used to serve only uninsured and underinsured adults.

It is estimated that approximately 11% of younger children and up to 20% of teens nationwide are not fully insured for vaccines (National Immunization Survey, Insurance Module). Population estimates for 2012 provided by the Centers for Disease Control and Prevention (CDC) indicate that approximately 302,435 children 0-18 years of age in Virginia (15%) are underinsured. An estimated 288,728 (95.5% of total underinsured) currently are not covered by VFC because they are not seen in an FQHC or RHC.

- *Virginia Immunization Information System* is Virginia's statewide immunization registry for both the private and the public sectors. It is a free web-based system that consolidates vaccination records from multiple providers into one record. VIIS is now available to health care professionals throughout the state and has a current enrollment of over 2,000 providers.
- *Virginia Perinatal Hepatitis B Prevention (VPHBP) Program* is a collaborative effort with LHDs and private providers to identify hepatitis B surface antigen (HBsAg) positive pregnant women, their household contacts, and sexual partners. Once identified, free testing and vaccine, if needed, is provided to the contacts and partners of these women. Free hepatitis B immune globulin (HBIG) and hepatitis B vaccine for newborns of infected mothers are provided to the delivery hospital and the infant's physician to protect the infant from developing chronic hepatitis B disease.
- *Virginia Adult Hepatitis B Immunization Initiative (VABHII)* is a collaborative effort between VDH's DOI, LHDs, and community partners to identify adults at high risk for hepatitis B infection and to provide free hepatitis B vaccine to these individuals for the prevention of hepatitis B infection.
- *Vaccine-Preventable Disease Surveillance and Epidemiology*—Disease reporting and investigation are critical parts of the prevention and control of communicable diseases. In order to eliminate vaccine-preventable diseases, aggressive efforts must be made to identify factors that allow cases to continue. Most vaccine preventable diseases are reportable by law in Virginia. They include, but are not limited to diphtheria, *Haemophilus influenzae*, measles, mumps, pertussis, poliomyelitis, rubella, *Streptococcus pneumoniae*, tetanus, and varicella. Diseases such as diphtheria, *Haemophilus influenzae*, measles, pertussis, and poliomyelitis should all be reported to VDH immediately by the most rapid means available. Other diseases should be reported within 3 days of diagnosis.
- *Vaccine Data and Statistics* are gathered nationally and locally to ensure that children receive appropriate and timely immunizations so as to prevent the occurrence of vaccine-preventable diseases. VDH conducts an annual immunization survey for the children enrolled in kindergarten, day care, Head Start programs, and 6th grade. Progress reports are prepared quarterly by DOI for local health departments to track progress toward meeting goals in the following areas: adolescent coverage, coverage at 24 months of age, doses administered, funding accountability, inventory accountability, and time to data entry.
- *School Requirements*—VDH's annual survey assesses compliance with attendance requirements at school entry. Each state health department also collects data on various health behavior and risk factors for disease, including adult immunizations, which are reported to the CDC. All of these surveys contribute to assessing progress toward the Healthy People 2020 objectives with the ultimate goal of improving the nation's health.

- *Vaccine Safety*—VAERS (Vaccine Adverse Event Reporting System) is the national vaccine safety surveillance program co-sponsored by the CDC and the Food and Drug Administration. VAERS collects and analyzes information from reports of adverse events following immunization. DOI receives and reviews some adverse event reports, sends them to the CDC, and provides additional follow-up information when needed.
- *International Travel*—DOI provides a list of international travel vaccination sites and issues licenses to physicians wanting to administer yellow fever vaccine.

Expectations and Scope of Immunization Advisory Committee—Mr. Farrell noted that the committee is expected to perform the following:

- Provide guidance and serve as an advisory body to the Division of Immunization
- Address issues related to best practices in immunization in a clinical setting, vaccine supply, vaccine legislation, vaccine preventable disease control, and other key programmatic issues as they arise
- Meet quarterly beginning in January 2013 (The next start-up meeting is scheduled for October 30, 2012, from 9 to 11 a.m., and more information on both will be provided.)
- Serve for the either 2- or 3-year terms with 1-year extension option. (VDH staff will serve 2 years and non-VDH staff will serve 3years.)

Mr. Farrell noted that the DOI will provide an agenda prior to and minutes following each meeting. He then reviewed the membership list noting the following types of organizations that are serving:

- *Coalitions* (Virginia Native American Community; Project Immunize Virginia; Virginia Community Health Association)
- *Hospitals/Medical Schools* (Martha Jefferson Hospital; Children’s Hospital of The King’s Daughters; Eastern Virginia Medical School; Reston Hospital Center; VCU Health System)
- *Health Insurance* (Anthem BC/BS; Virginia Association of Health Plans)
- *Professional Societies* (Virginia Hospital and Healthcare Association; American Academy of Family Physicians-VA; Virginia College of Emergency Physicians; American Academy of Pediatrics-VA; Virginia Pharmacists Association; American Congress of OB/GYNs-VA; Virginia Nurses Association)
- *Provider/Medical Group* (Sentara Pediatric Physicians-Gloucester; International Adoption and Travel Medicine Clinic; Virginia Association of Free Clinics; Patient First)
- *State Agencies* (Virginia Department of Health; Virginia Department of Medical Assistance Services; Virginia Department of Education)

Dr. Berg inquired as to whether the American College of Physicians, which represents internal medicine physicians, was contacted about service on the advisory committee. Dr. Forlano confirmed that it was. Dr. Berg volunteered to follow up on a response.

Mr. Farrell emphasized that since the face of public health is changing, it is critical for this committee’s collaboration, expertise, and guidance during the transition period to maintain best practices and supply availability.

Dr. Forlano encouraged members to ask questions and offer ideas that will assist committee organizers in determining what issues and information are important for discussion and review.

Data Snapshot and Questions/Comments from Committee—Rebecca Early presented data on morbidity and vaccination coverage. (A copy of the presentation and Ms. Early’s comments are attached.)

Dr. Puritz asked about the rate of VIIS participation by providers. Mr. Farrell responded that it is hard to determine the denominator. He noted that although there is significant participation in VIIS, records are incomplete. Records are provided mostly by third parties, health insurance companies, and a smaller number of providers. The conclusion was reached by all that it is safe to assume data on Slide 7 is underreported and represents a moderate percentage.

Dr. Ashby posed a question regarding the efficacy of Tdap vaccine and clinical studies. On 7/19/12 CDC referenced studies conducted on Tdap and DTP: “While acellular pertussis vaccines provide excellent immediate protection, the increased rates of pertussis in adolescents fully vaccinated with acellular vaccine during childhood suggests early waning of immunity after Tdap vaccination. Despite this increase, pertussis vaccination remains the single-most effective strategy to prevent infection. The focus of control and prevention efforts includes protecting infants and improving vaccination coverage in adolescents and adults, especially pregnant women and others who have close contacts with infants.” This may be evidence that is playing into the data results. Studies to examine this question are being developed at the federal level (slide 12).

Dr. Kulberg asked if the vaccine coverage data was locality-specific, and a discussion ensued regarding the prohibitive cost of collecting the data from LHDs. In short, coverage data is available on most childhood vaccines at the state level only. There are complementary surveys (annual school survey) that provide some level of data but not to the desired level. In order to get further geographic detail, it would be necessary to pay for oversampling at certain jurisdictional levels, etc. Dr. Forlano and Mr. Farrell noted that increased participation in VIIS, with the help of the LHD community surveys, would improve regional data for children and VIIS.

Dr. Moneymaker asked about hepatitis B with respect to shared glucose monitors at long-term care facilities. Dr. Forlano directed the members to the *CDC MMWR*, May 18, 2012, issue, which has more details. She also noted that VDH is working with the Department of Social Services with respect to training staff and potential regulation changes to optimize prevention in these congregate settings.

Dr. O’Dell noted that the data and discussion does not address a vaccine against rabies and that veterinarians are choosing not to vaccinate themselves. Mr. Farrell explained that VDH funding is very specific and not available for rabies. Dr. Forlano will discuss the issue with Dr. Murphy, VDH State Public Health Veterinarian.

Current Topics— Jim Farrell presented programmatic and policy updates, a copy of which is included in the attached presentation. The topics presented are as follows:

Programmatic Updates

- Pertussis Prevention Task Force—recommendations were released this summer to the Health Commissioner.
- Hepatitis B prevention
 - Hepatitis B work group to address outbreaks

- VDH monitors blood test results for pregnant females, treats, and follows through to pediatrician. In 2011 VDH treated 257 children, and 74% did complete the series. According to the CDC, we should be identifying 500 to 800 females that could be served through this program (may be somewhat high).
- Grant opportunities beyond our base grant
 - Billing grant—already awarded; provides enhanced tracking and billing system to track expenditures and revenue at LHDs.
 - Adult immunization grant—waiting on notification of award for the adult immunization grant; includes adult hepatitis B component that focuses on increasing outreach to minorities and funds for different projects that focus on partnering with the following:
 - Pharmacies to expand use of VIIS and provide a wider array of adult vaccines
 - Workplaces to develop employee policies focusing on immunization of employees or improve accessibility and coverage levels
 - DMAS to improve adult vaccinations and expand use of VIIS.
 - Pending cooperative agreement—requested funds for vaccine handling and storage (central and statewide); interface with CDC ordering distribution system; and additional resources to expand high-risk adult hepatitis B coverage. CDC’s movement to cooperative agreements rather than grants means a more active role by CDC in the funded program through monthly reports and conference calls.
- CDC requirement of Strategic Plan to Improve Immunization Rates—CDC is requiring DOI to develop a 5-year strategic plan on how it will increase child and adult vaccine coverage. This is an ambitious plan but important, and committee involvement is critical. It will be added to the October agenda.
- Recent VDH-DOI special projects:
 - With year-end monies available, DOI was authorized to purchase additional Tdap, HPV and meningococcal vaccine for LHDs to target those individuals who are uninsured or underinsured.
 - Pilot projects—meningococcal vaccine for underinsured and uninsured adults who meet the age criteria for the vaccine with a focus on students attending college in the fall; HPV vaccine for females 19 to 26 years and males 19 to 21 years who are uninsured or underinsured; and Tdap vaccine for underinsured and uninsured adults.

Policy Updates

- Base funding—total budget from CDC \$63.8 million (base grant) authorized under 317 Act and \$3.7 million state general funds. See slide 23 for details. The vaccine we get from the federal government is similar to a charge account using federal procurement contractors; it is not money that we receive. 2012 was the 5th and last year in the grant cycle, and January 2013 starts a new cycle.

- 317 funding guidance—effective October 1, 2012, 317 funding from CDC can no longer be used for insured individuals’ vaccines. There may be exceptions for school clinics. 317 funds have been reduced 20%. The Federal view is that as more people become insured, there is less need for funding: the trend will be to use 317 vaccine funds more for adult vaccine programs than for children’s immunization services.
- LHD deputization—VFC is a federal entitlement program used to provide vaccines to eligible children. Currently in Virginia, children who meet VFC eligibility due to underinsured status can receive VFC vaccine only at an FQHC/RHC. If VDH elects to pursue the deputization of LHDs, these children would be able to receive VFC vaccine in our LHDs through deputization agreements. Many states already have deputized due to the new 317 funding limitations. We believe the next initiative at VDH is to deputize LHDs to act as FQHC/RHC in order to vaccinate VFC-qualified children. If Dr. Remley approves, we must file the request with CDC by October 1.

Questions and Answers

- Dr. Bryan-Allison asked if individual physicians can be deputized? Dr. Forlano noted that it would be difficult to meet the criteria that would allow private providers to be deputized in Virginia (presence of local health departments, geographic criteria, etc.). In theory, this population is going to shrink with the Affordable Care Act, which mandates that health plans cover all routine childhood immunizations. The underinsured that don’t meet the definition will be harder to serve (federal law 2010 preventive care, including vaccines, are covered at no out-of-pocket cost).
- Dr. Moneymaker noted that the underinsured (that don’t meet the VFC definition of underinsured) are going to slip through the cracks—for example, those who are poor have transportation challenges—it is likely we will see immunization rates decline within this group.
- Dr. O’Dell suggested VDH form partnerships with providers in those cases. Dr. Forlano and Mr. Farrell explained that the providers can’t provide VFC vaccine but agreed that partnerships can be formed locally to optimize and maximize vaccine services to children. Farrell: For example, school-based clinics are an option. Not taking away VFC, rather 317 funding. The committee will be informed when the underinsured item comes into play.
- Dr. Moskowitz asked what percentage of teenage males and females test positive? Mr. Farrell noted that HPV is not reportable; therefore, VDH doesn’t have that data. Part of the rationale is there are different strains.
- Dr. Moskowitz then asked about meaningful use and reporting to VIIS—what is the state doing to improve reporting via EMRs? Mr. Farrell reported that VDH is prepared for vaccine records internally, but the overall state plan is to be determined. This item will be added to the October agenda.

Open Discussion—Brief data reports and an update on programmatic issues will be provided at each meeting. Any questions in between meetings should be directed to Mr. Farrell (804-864-8087 or jim.farrell@vdh.virginia.gov).

- What would a 5-year strategic plan look like that would help us to reach our goals? Reduce VPD morbidity by increasing vaccination rates across the life span. Volunteers from the group are needed to work this plan, which is due to CDC at the end of October 2012 and January 2013.

- Issues from the field need addressing; let VDH know what is working and what is not.
- As legislative season comes upon us, VDH will provide legislative updates as they occur.
- Dr. Trump asked the committee for suggestions for the October meeting and received the following comments:
 - Dr. Berg posed the efficacy of the DTAP and Tdap vaccines; and Dr. Forlano noted the CDC provides clinical updates, which VDH will pass on to the committee.
 - Dr. Allison-Bryan noted there is no data on 6th grade girls receiving HPV. Caroline Campbell responded that since it is not required and opt-out paperwork is not done, we don't have the data.
 - Lauren Bull asked if there is HPV data via VDH and noted that it would be good to have for General Assembly season. Agreed—but hard to compare public vs. private data because we don't have complete data. Half of all teens in Virginia received at least 1 dose and 78% completed the series. Message is “get them started.”
 - Dr. Trump posed the question: Now that males are being urged to get the vaccine, will that change legislation?
- Other items for next meeting:
 - Strategic plan
 - Philosophical exemption—how to increase message of protective factor
 - Information on shingles and the vaccine (new ACIP recommendation is lowered to 50) 14% vaccinated at age 60+
 - How can we increase the use of VIIS and community-level data? How can we all help? Mr. Farrell suggested Greg Dennis present this information at the next meeting. Additionally, he noted that vendors have made modifications to help providers use VIIS more easily and effectively.
 - Getting information from the military health system, especially the eastern region.

Closing—Dr. Forlano provided closing remarks and thanked everyone for their time and input. The meeting ended at 10:37 a.m.